

## Permanency Plan for Child in Custody

### Section 1

Case Name:				Facts Case #:		CO:	
Child Name:			DOB:		Court Case #:		
Local DCF Office:			Assigned DCF Staff:				
Provider:			Assigned Provider Staff:				
Case Planning Conference Date:							

### Section 2

Reason for Agency Involvement (Include Family Perspective):

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Family/Individual Strengths and Resources :

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Permanency Goal (check one of the following):

<input type="checkbox"/> Maintain at home	<input type="checkbox"/> Reintegration	<input type="checkbox"/> Adoption	<input type="checkbox"/> Custodianship/Guardianship <input type="checkbox"/> with relative <input type="checkbox"/> with non-relative	<input type="checkbox"/> OPPLA	
Concurrent Plan (if applicable and Reintegration also goal):			<input type="checkbox"/> Adoption	<input type="checkbox"/> Custodianship/Guardianship	<input type="checkbox"/> OPPLA
Child Receiving HCBS Services:		<input type="checkbox"/> yes	<input type="checkbox"/> no		
Type of HCBS Waiver Service:	<input type="checkbox"/> I/DD	<input type="checkbox"/> SED	<input type="checkbox"/> TBI	<input type="checkbox"/> TA	<input type="checkbox"/> Autism

### Section 3

What will happen if this plan is met:

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What will happen if this plan is not met:

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Summary of Progress made toward achieving the case plan goal since last Case Plan:

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**Section 4** Include at least one and no more than 3 permanency objectives, incorporating family strengths.

Permanency Objective # \_\_\_\_\_

Task #	Measurable Short-Term Tasks Toward Achievement of Goal	Court Ordered	Responsible Person	Target Date	Achieved Date

Criteria for Success

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Permanency Objective # \_\_\_\_\_

Task #	Measurable Short-Term Tasks Toward Achievement of Goal	Court Ordered	Responsible Person	Target Date	Achieved Date

Criteria for Success

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Permanency Objective # \_\_\_\_\_

Task #	Measurable Short-Term Tasks Toward Achievement of Goal	Court Ordered	Responsible Person	Target Date	Achieved Date

Criteria for Success

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### Section 5

Interaction/Visit Plan – Note the general plan for contacts. Specific schedule shall be documented on the PPS 3053.

Parent/Child:

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Sibling:

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Worker/Child:

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Worker/Mother:

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Worker/Father:

### Section 6

Placements: Attach print out of current placement and all placements since last case plan. For each placement, document if it was safe, meets the needs of the child, least restrictive, consistent with the best interest of the child, in close proximity to parents (if reintegration is the CP goal), and how proximity to home school and appropriateness of the child's educational setting was considered.

Placement #	Is/Was Placement Safe?	Does/Did Placement Meet the Needs of the Child?	Is/Was Placement Least Restrictive?	Is/Was Placement In Close Proximity to Parents?	Is/Was Placement In Close Proximity to School?	Is/Was Educational Setting Appropriate?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Explanation For Any No Answers:

Reason for Moves and Child's Reactions to Move:

How maternal and paternal relatives were considered for placement since the last case plan:

### Section 7

Child/Youth Plan (to assure well-being and stability while in custody)

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Summary of child well-being of child since last Case Plan (include authorization for sleepovers, self-care, physical restraint, driving, or high risk activities when applicable.):

Child Well-Being Status:					Specific Needs to be Addressed:	
	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Identified Need	Number of Task that Addresses
Medical/Dental/Vision Needs	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		
Mental Health Needs	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		
Developmental Disability Needs	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		
Alcohol/Drug Treatment Needs	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		
Social and Emotional Needs	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		
Educational Needs	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		
Placement Needs	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		
ICWA Determination Need	<input type="checkbox"/>	yes	<input type="checkbox"/>	no		
Received Timely Treatment for:						
Medical Needs	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	NA
Dental Needs	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	NA
Vision Needs	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	NA
Mental Health Needs	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	NA

### Section 8

Participants' Signatures/Dates (For non-family participants, information shared is confidential and shall not be released.)

	Printed Name	Signature	Participation Code	Date
Child				
If age 14 or older, my signature acknowledges that I received and had explained: Appendix 7D, Do you Know Your Rights as a Kansas Foster Youth; my health rights; and the right to have an annual credit check.				
GAL				
CASA				
3 <sup>rd</sup> Party				
IL Coordinator				
CWCMP Case Manager				
DCF staff				
Therapist				
Educator				
Foster Parent				
Waiver Case Manager				
Other				

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Other				
Other				
Participation Codes: IP – participated in person, BP – participated by phone, NI – provided input				
Parent Signatures: I have participated in the development of this plan. I understand this signed case plan may be released to participants in this plan and they may share information among the participants necessary to implement the plan.				

_____	_____	_____	_____
<b>Parent Signature</b>	<b>Date</b>	<b>Parent Signature</b>	<b>Date</b>
_____	_____	_____	_____
<b>Parent Signature</b>	<b>Date</b>	<b>Parent Signature</b>	<b>Date</b>

